

FOR STATE  
HEALTH DEPT.

00820

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00820

1. PLACE OF DEATH a. COUNTY <b>Kent County, Maryland</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. Rock Hall, Md.</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>		d. STREET ADDRESS <b>R.F.D. Rock Hall, Maryland</b> 19.1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dwayne Beck</b>		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/1962</b>
9. AGE (In years last birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Clarence Beck</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Tilghman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dorothy Tilghman</b>		Address <b>R.F.D. #1 Rock Hall, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>916.0 Burned to death in house fire</b> DUE TO <b>Multiple severe Burns</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Blood drawn for carbon monoxide</b> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>See above, Was alone in house with 2 siblings</b>	
20c. TIME OF INJURY Month, Day, Year <b>11-12 a.m. 1/14 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Rock Hall (rural) Kent, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert R. Farr</b>		22. DATE SIGNED <b>1/16/67</b>	
EXAMINER'S NAME (Type) <b>Robert R. Farr M.D.</b>		Address (Street, city, town, or county) <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Aaron Chaple Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>R.F.D. Rock Hall Kent Md</b>	
24. FUNERAL DIRECTOR <b>Samuel W. Wally</b>		ADDRESS <b>Chestertown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00300

00300

FOR STATE  
HEALTH DEPT

00821

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00821

1. PLACE OF DEATH a. COUNTY <b>Kent County, Maryland</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. Rock Hall, Md.</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>				d. STREET ADDRESS <b>R.F.D. Rock Hall, Maryland</b>			
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Beck</b> Last <b>Beck</b>				4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/8/1964</b>	9. AGE (In years lost birthday) yts. <b>2</b>	IF UNDER 1 YEAR Months <b>14</b> Days <b>16</b> Hours <b>7</b> Min.	IF UNDER 24 HRS. Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Beck</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Tilghman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dorothy Tilghman</b> Address <b>R.F.D.#1 Rock Hall, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>9/16-0</b> IMMEDIATE CAUSE (a) <b>Multiple Severe Burns</b> DUE TO <b>Burned to death in house fire, while alone there with 2 siblings</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>there with 2 siblings</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>short</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>see above</b>					
20c. TIME OF INJURY Month, Day, Year <b>1-12 our a.m. 1/14/67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, for, or office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>(Rural) Rock Hall, Kent, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>None</b> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.R. Farr</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Robert R. Farr M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Aaron Chaple Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>R.F.D. Rock Hall, Kent Md.</b>	
24. FUNERAL DIRECTOR <b>Kenneth W. Daley</b> ADDRESS <b>Chestertown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18300

18310

FOR STATE  
HEALTH DEPT.

00822

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00822

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent County, Maryland</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. Rock Hall, Md.</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>		d. STREET ADDRESS <b>R.F.D.#1 Rock Hall, Maryland 14.1</b>	
3. NAME OF DECEASED (Type or print) First <b>Monique</b> Middle <b>Beck</b> Last <b>Beck</b>		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1963</b>
9. AGE (In years lost birthday) yrs <b>3</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Beck</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Tilghman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dorothy Tilghman</b>		Address <b>R.F.D.#1 Rock Hall, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Multiple Severe Burns</b> IMMEDIATE CAUSE (a) <b>916.0</b> DUE TO (b) <b>Burned to death in fire, while alone at</b> DUE TO (c) <b>home with 2 siblings</b>		INTERVAL BETWEEN DEATH AND DEATH <b>Short</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>see above</b>	
20c. TIME OF INJURY Month, Day, Year <b>11-12</b> a.m. <b>1/14/67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>(Rural) Rock Hall, Kent, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert R. Farr</b> M.D.		22. DATE SIGNED <b>1/16/67</b>	
EXAMINER'S NAME (Type) <b>Robert R. Farr M.D.</b>		Address (Street, city, town, or county) <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Aaron Chaple Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>R.F.D. Rock Hall, Kent Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		ADDRESS <b>Chestertown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00883

00883

00883

non above

1/10/87

1/10/87



00823

## CERTIFICATE OF DEATH

00823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>3 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		d. STREET ADDRESS <b>118 North Queen Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elsie Mae Brown</b>		4. DATE OF DEATH Month Day Year <b>Jan. 14 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1897</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EX Telephone Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Joseph Gordon (D)</b>		14. MOTHER'S MAIDEN NAME <b>Ludella Eshan (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-16-6569</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ADENOCARCINOMA OF ENDOMETRIUM</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 YR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ILEMIA</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-28</b> , 19 <b>66</b> , to <b>1-14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-14</b> , 19 <b>67</b> , and that death occurred at <b>4:20</b> P.M., from causes on and on the date stated above.			
22a. SIGNATURE <b>Harry Paul Ross</b>		22b. DATE SIGNED <b>1-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry Paul Ross</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>Pa</b>
24. FUNERAL DIRECTOR <b>J. Peter Daniels - Middletown, Del</b>		25a. REC'D BY REGISTRAR <b>Jan 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

00000

STATE OF TEXAS

00000

RECEIVED  
JAN 10 1900  
JAN 10 1900



OFFICE OF THE COMMISSIONER OF THE GENERAL LAND OFFICE  
DAVID C. DAVIS, Commissioner  
JAN 10 1900



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>00824</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00824</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> c. LENGTH OF STAY IN 1b <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sharptown</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> d. STREET ADDRESS <b>Sharptown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H.</b> Last <b>Butler</b>					4. DATE OF DEATH Month <b>Jan.</b> Day <b>12</b> Year <b>19 67</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/18/1890</b>		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>yard man</b>			11. BIRTHPLACE (State or foreign country) <b>St. Marys County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Butler</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Johnson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>217 54 5321</b>		17. INFORMANT <b>Edward Parker</b>		Address <b>Rock Hall, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Was visiting sister and fell dead at her home.</b> DUE TO (c) <b>home.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>1/14/67</b> EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b> Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharptown cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall Kent Md.</b>		
24. FUNERAL DIRECTOR <b>Marvin V. Williams</b>					ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

00000

00000

Land

Land

Rock Hill

Rock Hill

Rock Hill

Shelburne

Shelburne

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

Is

00825

CERTIFICATE OF DEATH

00825

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN b <b>46 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		d. STREET ADDRESS <b>Rt. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nellie Pauline Coleman</b>		4. DATE OF DEATH Month Day Year <b>1 13 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/17</b>
9. AGE (In years last birthday) <b>49 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kent Co. Health Dept.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>R. N.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Willaim Ray Crew</b>	
14. MOTHER'S MAIDEN NAME <b>Hattye NMN Boone</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW 11</b>	
16. SOCIAL SECURITY NO <b>220 26 3677</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinomatous</b> DUE TO (b) <b>Carcinoma of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> , 19 <b>66</b> , to <b>1/13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> , 19 <b>67</b> , and that death occurred at <b>12:35 P.M.</b> , from causes and on the date stated above. 22a. SIGNATURE <b>Dr. R. W. Farr</b> 22b. DATE SIGNED <b>1-15-67</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. R. W. Farr</b> 22d. ADDRESS <b>Chestertown, Maryland</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1/16/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b> 24. FUNERAL DIRECTOR <b>Willis Wells</b> ADDRESS <b>Chestertown, Md.</b> 25a. REC'D BY REGISTRAR DATE <b>JAN 18 1967</b> 25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00826

## CERTIFICATE OF DEATH

00826

1 PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent-Queen Annes Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>William Harvey Dew</u>		4 DATE OF DEATH <u>1</u> <u>2</u> <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-7-1888</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>AMER</u>	
13 FATHER'S NAME <u>Rullen Dew</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>218-03-0385</u>	
17 INFORMANT <u>Hospital Records</u>		Address <u>Chestertown</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>473X</u> IMMEDIATE CAUSE (a) <u>Pneumonia,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mucositis, duodenal &amp; enteric</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>67</u> , to <u>1-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-2</u> , 19 <u>67</u> , and that death occurred at <u>1230</u> P.M., from causes and on the date stated above.			
22a SIGNATURE <u>A. C. Dick</u> M.D.		22b. DATE SIGNED <u>1-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>		22d. ADDRESS <u>Chestertown, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>1/7/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	23d LOCATION (City or town) (County) (State) <u>CHURCH HILL, Q.A. MD</u>
24. FUNERAL DIRECTOR <u>Kenneth Wally</u>		25a REC'D BY REGISTRAR <u>DATE JAN 9 1967</u>	
ADDRESS <u>Chestertown, Md</u>		25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

00

2

1

130

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00827  
CERTIFICATE OF DEATH  
00827

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Md.				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Bertie Groce				4. DATE OF DEATH Month Day Year 1 2 1967			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1875	
9. AGE (In years last birthday) 91 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Various			
13. FATHER'S NAME Daniel Bulter				14. MOTHER'S MAIDEN NAME France Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. YES			
17. INFORMANT Mr. Murrill Groce				Address R.F.D.#1 Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4211 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiac Vascular DUE TO (c) Coronary Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Anterior							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1965, to 1-2-1967, that (I) (we) last saw the deceased alive on Jan 2, 1967, and that death occurred at 84M, from the causes and on the date stated above.							
22a. SIGNATURE Norbert C. Nitsch				22b. DATE SIGNED 1/5/67			
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch M.D.				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/1967		23c. NAME OF CEMETERY OR CREMATORY Aaron Chaple Cem.		23d. LOCATION (City, town or county) (State) R.F.D. Rock Hall, Md.	
24. FUNERAL DIRECTOR C. Emmett Webb				25a. REC'D BY REGISTRAR JAN 9 1967			
ADDRESS Chestertown, Md.				25b. REGISTRAR'S SIGNATURE			



FOR STATE  
HEALTH DEPT.

00828

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00828

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Kent County, Maryland</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>R.F.D. Worton, Md.</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>R.F.D. Worton, Maryland</b>		d. STREET ADDRESS <b>At Home</b>	
3 NAME OF DECEASED (Type or print) <b>Abbie</b>		4 DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years lost birthday) <b>77</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Turner</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-16-9886</b>	
17 INFORMANT <b>Mrs. Carrie Worton</b>		Address <b>R.F.D. Worton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Manner of death resembled that due to cardiac arrest due to unknown cause.</b> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Robert W. Farr</b> M.D.		22. DATE SIGNED <b>1/31/67</b>	
EXAMINER'S NAME (Type) <b>Dr. Robert W. Farr M.D.</b>		Address (Street, city, town, or county) <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/31/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>R.F.D. Worton Kent Md.</b>
24. FUNERAL DIRECTOR <b>Anneth W. W. W.</b>		25a. REC'D BY REG. STRAR DATE <b>FEB 3 1967</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00829

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00829

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>		c. LENGTH OF STAY IN 1b <b>lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton Kent Co. Md.</b>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Erwin Walter Landwehr</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 11, 1933</b>
9. AGE (in years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - furniture</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Landwehr</b>		14. MOTHER'S MAIDEN NAME <b>Edith Meekins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes Korean</b>		16. SOCIAL SECURITY NO. <b>420 28 4322</b>	
17. INFORMANT <b>Jane Dawkins Landwehr</b>		Address <b>Worton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO <b>Was found between front seats of closed panel truck with face close to tank of propane gas which had been turned on. Tank was empty.</b> (b) <b>Asphyxiation</b> DUE TO <b>Asphyxiation</b> (c) <b>Asphyxiation</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>See above</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>1/11/67</b>			
ACTUAL SIGNATURE <b>Robert W. Farr, M. D.</b>		EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown Md.</b>	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00830

00830

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> c. LENGTH OF STAY IN 1b <b>25 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sunnyland Farm</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rock Hall (25 yrs.)</b> d. STREET ADDRESS <b>Sunnyland Farm</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR ALLAN MITTEN</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Attica, Ind.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Dr. &amp; Phila Transit Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas E. Mitten</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Warner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 160 01 3319</b>	
17. INFORMANT <b>Gertrude Mitten</b>		Address <b>Rock Hall, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Manner of death suggestive of cardiac arrest.</b> DUE TO (c) <b>short</b>		INTERVAL BETWEEN ONSET AND DEATH <b>short</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		22. DATE SIGNED <b>1/20/67</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr Kent Co. Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department, of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
00831									
1. PLACE OF DEATH a. COUNTY <b>Kent</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At home, Lankford Bay Estates</b>					d. STREET ADDRESS <b>Lankford Bay Estates</b>				
3. NAME OF DECEASED (Type or print) <b>James Bayard Newnam</b>					4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1967</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 11, 1895</b>		9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James B. Newnam, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Miriam Walraven</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>220 36 9120</b>		17. INFORMANT Address <b>Wife</b> <b>Mariam Walraven Vera S. Newnam</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Had been in good health. Was found dead in bed about 6:00 A.M. Jan. 8, 1967.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)								INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert W. Farr, M. D.</b>			22. DATE SIGNED <b>1/10/67</b>						
EXAMINER'S NAME (Type)			Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Spec. fy) <b>Burial</b>			23b. DATE THEREOF <b>1/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crumpton, Md.</b>		
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/

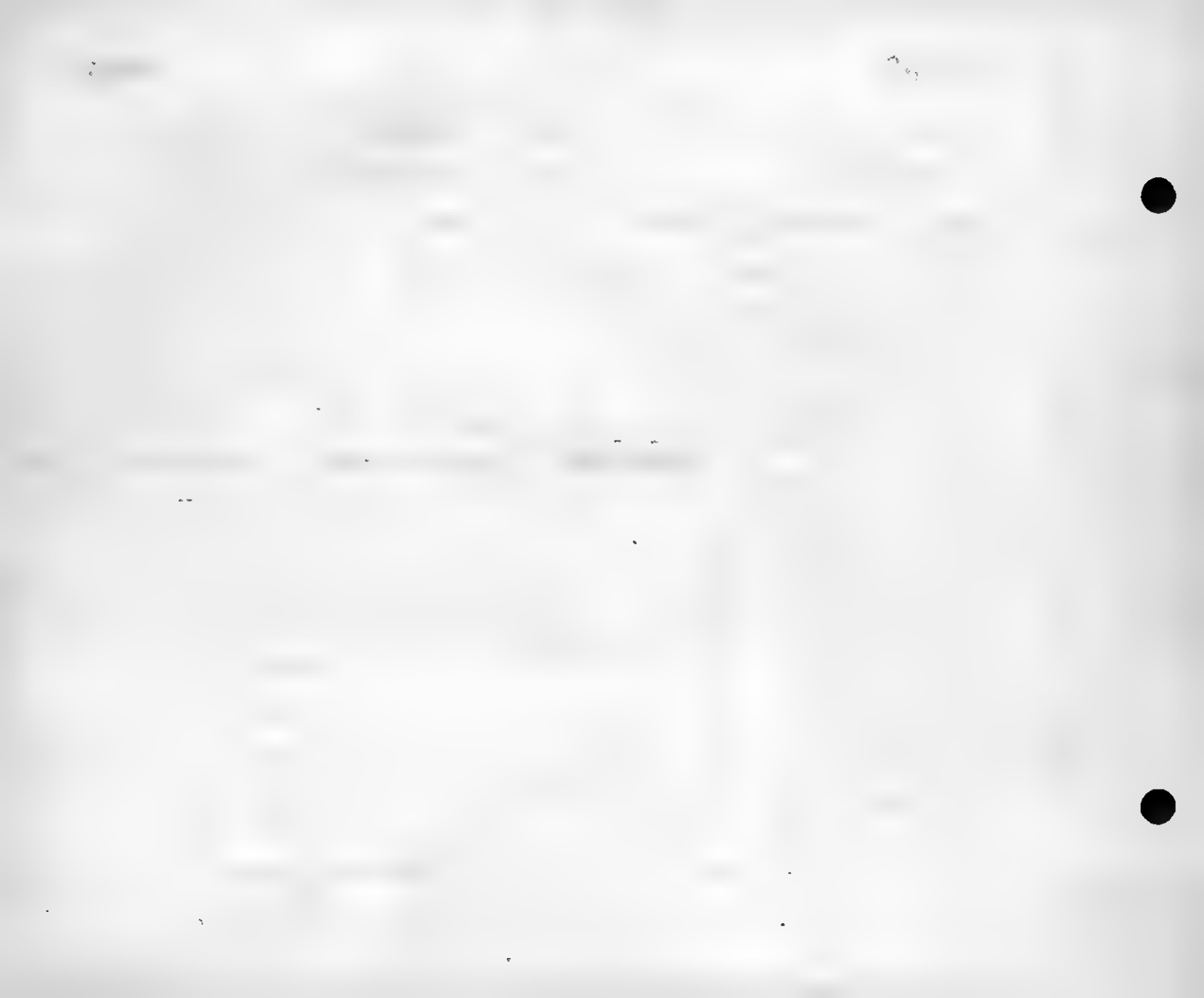
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00832

CERTIFICATE OF DEATH

00832

1 PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN It <b>9 1/2 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millington</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <b>Mary</b> First Middle Last <b>Mabel</b> <b>Phillips</b>		4 DATE OF DEATH Month Day Year <b>1</b> <b>4</b> <b>19 67</b>					
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-14-1897</b>	9 AGE (In years lost birthday) Yrs <b>69</b>	IF UNDER 1 YEAR Months Days <b>6</b> <b>9</b>	IF UNDER 24 HRS Hours Min <b>6</b> <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Albert Dunn</b>			14. MOTHER'S MAIDEN NAME <b>Mary Lou Bell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-9358</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage - Quadriplegia</b> DUE TO <b>722.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A.S.C.U.D</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>67</b> , to <b>1/4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>67</b> , and that death occurred at <b>2:25 A.M.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>J. P. Ross</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-4-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. P. Ross</b>		22d. ADDRESS <b>Chestertown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sudlersville, Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows,</b>			ADDRESS <b>Millington, Md. 21651</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00833						00833					
1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock HALL</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock HALL</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ELIZABETH</u> Middle <u>Price</u> Last			4. DATE OF DEATH Month <u>JAN.</u> Day <u>8</u> Year <u>1967</u>								
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 3 - 1878</u>		9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>x</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cecil Co. MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>THOMAS FORD</u>						14. MOTHER'S MAIDEN NAME <u>MARY E. MOORE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>217-30-7608</u>		17. INFORMANT Address <u>MRS. HESTER WILSON - FAIRLEE MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.A. Spina</u> (c) <u>C.A. Spina</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED while <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>67</u> , to <u>Jan 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>67</u> , and that death occurred at <u>10:24 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Norbert S. Nitsch</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-9-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>NORBERT S. NITSCH</u>						22d. ADDRESS <u>Rock HALL MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 11</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley CHAPEL</u>			23d. LOCATION (city, town or county) (State) <u>Rock HALL MD.</u>			
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>						ADDRESS <u>CHURCH HILL MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00834											
1. PLACE OF DEATH a. COUNTY <u>Kent County, Maryland</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R.F.D.# Chestertown, Md.</u>				c. LENGTH OF STAY IN 1b <u>20 Yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R.F.D.# Chestertown, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>At Home</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <u>Blanche</u> Middle <u>Alma</u> Last <u>Ringgold</u>			4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/11/1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Watkins</u>						14. MOTHER'S MAIDEN NAME <u>Victoria Unk.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>083-16-3885</u>		17. INFORMANT <u>Mr. Ernest Ringgold</u>			Address <u>Chestertown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> ~ DUE TO (b) <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-12-1963</u> , to <u>12-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-28</u> 19 <u>67</u> , and that death occurred at <u>12:40</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Rudolf Eglitis</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-23-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Rudolf Eglitis M.D.</u>						22d. ADDRESS <u>Rock Hall, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/26/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>R.F.D. Chestertown, Md.</u>			
24. FUNERAL DIRECTOR <u>John Delaney</u>						ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> DATE <u>JAN 27 1967</u>			



00835

CERTIFICATE OF DEATH

00835

1. PLACE OF DEATH a. COUNTY <b>Kent County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Annes Hospital</b>		e. STREET ADDRESS <b>Box 85 Route #2</b>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>?</b> Last <b>Stewart</b>		4. DATE OF DEATH Month <b>1</b> - Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/14/1914</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>28</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Coleman, Kent Co, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ame.</b>	
13. FATHER'S NAME <b>James ?NMN Moody</b>		14. MOTHER'S MAIDEN NAME <b>Martha ?NMN White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes 215-18-4149</b>	
17. INFORMANT <b>Burnice Stewart</b>		Address <b>Worton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-26</b> , 19 <b>67</b> , to <b>1-28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-28</b> , 19 <b>67</b> , and that death occurred at <b>5:30 p.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A.C. Dick M.D.</b>		22b. DATE SIGNED <b>1-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.C. Dick M.D.</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/4/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>R.F.D. Worton Kent Md.</b>
24. FUNERAL DIRECTOR <b>Bennett Fealy</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Chestertown, Md.</b>		DATE <b>FEB 3 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00832

Kent County

General

Kent + Green Pines Hospital

Eather

Female Negro

General Hospital

James 2MM Weekly

No

00833

Kent County

Marion

Lebanon

Box 82 Route #2

Stewart

6/11/41 22

Colman Kent, Maryland Pme

Martha 2MM White

RECEIVED TO DUTY



00836

## CERTIFICATE OF DEATH

00836

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>		c. LENGTH OF STAY IN lb <b>1-21 1-28</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Kent &amp; Queen Anne Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louis Garfield Wilson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1891/ 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FACTORY</b>	9. AGE (In years last birthday) yrs. <b>76</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Kent, Chesterville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>John Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Jannie Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>Miss. Olivia Wilson</b>		Address <b>R.F.D. Millington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>332X</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia due to BPH. Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>21 Jan, 1967</b> to <b>28 Jan, 1967</b> that (I) (we) last saw the deceased alive on <b>28 Jan 1967</b> , and that death occurred at <b>4 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wallace Obenshain</b>		22b. DATE SIGNED <b>30 Jan 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain M.D.</b>		22d. ADDRESS <b>Cecilton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/4/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Millington Kent Md.</b>
24. FUNERAL DIRECTOR <b>Kenneth Walby</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>FEB 7 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00830

UNITED STATES

00830

to be ...

...

...

...

...

J. M. ...